PURPOSE:
To outline the documentation on the Trauma Flow Sheet. This Flow Sheet is to be used for each level 1 or 2 Trauma Team Activations.

PROCEDURE:

Trauma Flow Sheet (Page 1)

1. Affix Patient label in top left-hand corner.
2. Complete Team Information, including documentation of time of arrival for ED Attending, Chief Surgery Resident, and Surgery Attending
3. Trauma Team Activation Information: This section is used to document the prehospital information received, including the following information:
    a. Name/DOB
    b. Notification Time, Activation Time
    c. Scene or Transfer Trauma
    d. Mode of Arrival (ambulance, helicopter, POV/triage, police, fixed wing), EMS Name
    e. Mechanism of Injury, Time of Injury
    f. Location in Vehicle (driver, passenger, front seat, back seat)
    g. Restrained, Air Bag Deployment, Use of Helmet
    h. Loss of Consciousness (LOC)
    i. Intubated
    j. Anticoagulant use, Type
    k. Blood Products Received
    l. Vital Signs (BP, HR, RR, GCS), Hypotensive – highest HR, lowest BP
    m. For transfer patients – CT scans, images pushed to TIR, Facility, Trauma Band #
4. Trauma Team Activation Response Criteria - Based on Trauma Team Activation policy - Check all categories that apply in the decision-making in the level of activation.
5. Signature of RN receiving initial call, Date, Time

Trauma Flow Sheet (Page 2)

1. Affix patient label top left hand corner
2. Document Arrival Date, Time, Trauma Band #
3. Document Initial Assessment
    a. Body Diagram - Utilize this section to denote location and type of injury.
    b. A – Document assessment of Airway, Trachea, Spine Precautions, Tympanic Membrane, Nose, Drainage (ears, nose)
    c. B – Document assessment of Breathing, Breath Sounds, O2 Device, Chest Movement, Chest, Chest Tubes, etCO2
    d. C – Document assessment of Circulation (capillary refill, manual BP), Skin, Neck Veins, Pulses

e. D – Document assessment of Disability, GCS, Pupils (size, reactivity), Sensation, Grips, Movement/Strength
f. E – Document Abdomen, Pelvis, Back, Bowel Sounds, FHTs (if applicable), GU, Rectal Tome

Trauma Flow Sheet (Page 3)

1. Affix patient label top left hand corner
2. Document Procedures Performed and Time
3. Radiological Studies Section: Utilize this section to document the time radiographic studies are performed. Studies not listed can be hand written into the blanks provided.
4. Document Medications administered (include time, medication name, dosage)
5. Document Intake (include crystalloids, contrast, oral, blood products) Total
6. Document Output (include urine, emesis, OGT/NGT, chest tube, other) Total

Trauma Flow Sheet (Page 4)

Initial vital signs must be performed within 30 minutes of patient arrival (including manual BP and temperature)

1. Affix patient label top left hand corner
2. Document Manual BP and time
3. Document Initial Temperature and time
4. Document vital signs throughout initial assessment and resuscitation period, including
   a. Time
   b. Temperature
   c. Pulse (HR)
   d. Respiratory Rate
   e. NIBP
   f. SPO2
   g. Pain Score
   h. EtCO2 (if patient is intubated)
   i. O2
   j. GCS (including eye, verbal, motor) - GCS should be recorded on arrival on all patients. Sequential reassessment should be done on all patients with suspected head injury frequency is based on patient condition but a minimum of hourly.
   k. Pupil size and reactivity - Pupillary size and reaction to light to be recorded on arrival on all patients. Sequential reassessment should be done on all patients with suspected head injury frequency is based on patient condition but a minimum of hourly.
   l. Comments
5. Domestic Screen is part of the Secondary Trauma assessment once the patient is stabilized if the patient is too critical for this to be done the not assessed due to the severity of illness box #9 need to be checked.

6. Safety fall risk is part of the Secondary Trauma assessment once the patient is stabilized if the patient is too critical for this to be done the not assessed due to the severity of illness box #9 need to be checked.
7. Barriers to learning is part of the Secondary Trauma assessment once the patient is stabilized if the patient is too critical for this to be done the not assessed due to the severity of illness box #9 need to be checked.
8. Not assessed due to severity of illness box.
9. Narrative Section: This section can be utilized to document additional Mechanism of Injury (MOI) information, narrative description of assessment/injury, ongoing assessment related to medications, procedures, etc, and other nursing documentation
10. Document RN signature, date, and time the transition to Epic is made

Trauma Flow Sheet (Page 5)

This Form shall be used when Massive Transfusion Protocol or Emergency Blood Safe is used.

1. Affix patient label top left hand corner
2. For use of Massive Transfusion/Emergency Blood Safe products
    a. Document Emergency Blood Safe Activation Time
    b. Document Massive Transfusion Activation Time
    c. Document Ordering Physician
    d. Document names of 2 Administering RNs
    e. Document product used (use sticker if available), time up, volume administered – there is a separate column for Whole Blood, PRBC, Plasma, Platelets, Cryoprecipitate
3. Document Blood Product Total Volume Infused (add to total intake on page 3)
4. RN signature, date, time